

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06328
Reg. Dist. No. 302

1. PLACE OF DEATH. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>R.D. #5 Ringgold</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Baby</u>	(Middle) <u>Boy</u>	(Last) <u>Baker</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6-20-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9. AGE last birthday <u>10</u> yrs. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
13. FATHER'S NAME <u>Dwight Westley Baker</u>		14. MOTHER'S MAIDEN NAME <u>Delores May Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		18. MEDICAL CERTIFICATION <u>Delores M. Baker</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Prematurity -</u>			
Antecedent cause(s) (b) <u>776X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>159</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5:10 P.M. 6-20-51, 1951, to 5:10 P.M. 6-20-51, that I last saw the deceased alive on 6-20, 1951, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arthur Baptist Jr. M.D. ADDRESS Hagerstown Md. DATE SIGNED 6-20-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/21/51</u>	<u>Bellview Cemetery</u>	<u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 21, 1951</u>	<u>W. H. Bowers</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown Md</u>	

206201244280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Dauphin</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> TOWN <u>Harrisburg</u> STREET ADDRESS (If rural, give location) <u>1208 Chestnut Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Arthur</u>	(Last) <u>Baptisti</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 1, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit & Produce</u>	11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Pa.</u>
13. FATHER'S NAME <u>Peter G. Baptisti</u>		14. MOTHER'S MAIDEN NAME <u>Susan Fidle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>278-18-0985</u>	17. INFORMANT AND ADDRESS <u>Dr. Arthur Baptisti Jr.-Hagerstown Md.</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Broncho Pneumonia4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral thrombosis4 yrs.(c) Arteriosclerosisyrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mellitus - mild.5 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1947, to June 6, 1951, that I last saw the deceasedalive on June 6, 1951, and that death occurred at 11:35 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 8, 1951Phyllis H. HoversonMarion J. BairlandClear Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 76

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JUN 11 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06330

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1 South Mont Valla</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Data</u>	(Middle) <u>R.</u>	(Last) <u>Baughman</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>6-4-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67 yrs.</u>
13. FATHER'S NAME <u>Frank P. Alsip</u>		14. MOTHER'S MAIDEN NAME <u>Annie I. Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Leoda M. Hickey, Hagerstown, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH
11 days

Antecedent cause(s)

(b) Hypertensive vascular disease

yrs.

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jun. 11, 1951, to Jun. 22, 1951, that I last saw the deceased

alive on Jun. 22, 1951, and that death occurred at 7:20 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-25-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REG. <u>June 25, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>C. M. Suter & Sons, Hagerstown, Maryland</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

720826

RECEIVED

JUN 27 1951

BUREAU 7. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06331

Reg. Dist. No. 353

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Big Spring</u> TOWN <u>Four Locks</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Four Locks</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Big Spring</u> TOWN <u>Four Locks</u> STREET ADDRESS (If rural, give location) <u>Four Locks</u>	
3. NAME OF DECEASED (Type or Print) <u>Harry Benjamin Bowers</u> (First) <u>Harry</u> (Middle) <u>Benjamin</u> (Last) <u>Bowers</u>		4. DATE OF DEATH <u>June 1, 1951</u> (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 30, 1875</u> yr. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>McCoy's Ferry, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Hart</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bowers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ella E. Bowers- Big Spring, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cronary Occlusion</u>			<u>Day</u>
Antecedent cause(s) (b) <u>420.1</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/31/51, 19....., to 6/1/51, 19....., that I last saw the deceased alive on 6/1/51, 19....., and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE <u>E. F. Young M.D.</u>		ADDRESS <u>Williamstown, Md.</u>		DATE SIGNED <u>6/2/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>June 4-51</u>		NAME OF CEMETERY OR CREMATORY <u>Green Spring Chapel Cem</u>	
LOCATION (City, town, or county) <u>Near Big Spring, Md.</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>June 4/51</u>		REGISTRAR'S SIGNATURE <u>J. W. Murray</u>		24. FUNERAL DIRECTOR <u>Adrian V. Rowland</u>	
				ADDRESS <u>Clear Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. At

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (in this place) 40 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital				STREET ADDRESS Hagerstown		(If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Emily Cecelia Brown		4. DATE OF DEATH (Month) (Day) (Year) 6 27 1951		5. SEX Female		6. COLOR OR RACE Negro	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 2-6-1890		9. AGE last birthday 61 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cable Nichols		14. MOTHER'S MAIDEN NAME Annie Jackson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs Alice Clinton Hagerstown		218 N Jonathans					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

generalized Peritonitis

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

(b)

Gangrene of Sigmoid c Perforation**5 days**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Ovarian Cyst, Lt, twisted + gangrenous**4 yrs +**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Calculus of Bladder

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6/25, 1951**, to **6/27, 1951**, that I last saw the deceasedalive on **6/27, 1951**, and that death occurred at **9:05 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTERER'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial**7-1-1951****Rose Hill Cemetery****Hagerstown Maryland****June 29, 1951****Blair H. Powers****John R. Watson****Hagerstown Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690448

RECEIVED

JUL 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06477

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) HIGHFIELD		CITY (If outside corporate limits, write RURAL and give nearest town) HIGHFIELD	
TOWN HIGHFIELD		TOWN HIGHFIELD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) William (Middle) Rufus (Last) Brown		4. DATE OF DEATH (Month) June (Day) 27 (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10/21/1881
9. AGE last birthday 69 yrs.		10. KIND OF BUSINESS OR INDUSTRY W.M. Railroad	
11. BIRTHPLACE (State or foreign country) Highfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Cynthia Wantz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. 184-07-3834	
17. INFORMANT AND ADDRESS Mrs. W. R. Brown, Highfield, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Chronic myocarditis					
Antecedent cause(s) (b) Carcinoma of Left Lung					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-27, 1951, to 6-29, 1951, that I last saw the deceased alive on 6-26-51, and that death occurred at 6:30 m., from the causes and on the date stated above.					
SIGNATURE Harvey C. Bridges		ADDRESS Blue Ridge Summit, Pa.		DATE SIGNED 6/29/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 6/29/1951		NAME OF CEMETERY OR CREMATORY Mt. Olivet	
LOCATION (City, town, or county) Hanover		(State) Pa.			
DATE REC'D BY LOCAL REG. June 29-51		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR [Signature] ADDRESS [Address]	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970506

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06333

2411 N. Charles Street, Baltimore

Dr Victor Miller

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown TOWN Hagerstown HOSPITAL OR INSTITUTION OR STREET ADDRESS 848 Spruce St.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown TOWN Hagerstown STREET ADDRESS (If rural, give location) 848 Spruce St.	
3. NAME OF DECEASED (First) LILLIE (Middle) E (Last) COLEMAN		4. DATE OF DEATH June 5 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Divorced	8. DATE OF BIRTH June 14 1884
9. AGE last birthday 66 yrs.		10. If under 1 year Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Smithsburg Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Victor Williams		14. MOTHER'S MAIDEN NAME Louise Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Leon M. Coleman Cumberland Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Sudo Carditis	INTERVAL BETWEEN ONSET AND DEATH 10 years &
Antecedent cause(s) (b) Chronic Nephritis -	10 years (?)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 0	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) Hagerstown	(COUNTY) Washington	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY June 4 1951	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? While at work		

22. I hereby certify that I attended the deceased from **Jan 1, 1950**, to **June 5, 1951**, that I last saw the deceased alive on **June 4, 1951**, and that death occurred at **8 a.m.**, from the causes and on the date stated above.

SIGNATURE **Dr. Victor B. Miller** (Degree or title) ADDRESS **131 W. WASHINGTON ST. HAGERSTOWN, MD.**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-7-51	NAME OF CEMETERY OR CREMATORY Hagerstown Wash. Co Md	LOCATION (City, town, or county) Hagerstown Wash. Co Md	(State) Md
DATE REC'D BY LOCAL REG. June 5, 1951	REGISTRAR'S SIGNATURE Robert H. Bowers	24. FUNERAL DIRECTOR ADDRESS Andrew K. Coffman Hagerstown Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06334 306

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodbine</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS <u>RF D #1</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Muriel</u> (First) <u>Lucinda</u> (Middle) <u>Conaway</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>5</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>Aug 6, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63 yrs.</u> If under 1 year Months. If under 24 hrs. Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Brice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Aspiration pneumonia</u>				<u>2 weeks</u>	
Antecedent cause(s) (b) <u>Left hemiplegia</u>				<u>3 yrs 8 mo</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cerebral thrombosis, recurrent</u>				<u>3 yrs 8 mo</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, General</u>				<u> yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept 1, 1951, to June 5, 1951, that I last saw the deceased alive on June 5, 1951, and that death occurred at 4:35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Axel A. Paas, M.D. Ritchie Hosp., Cascade, Md. 6-5-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Bethel Church of God Cemetery</u>	LOCATION (City, town, or county) <u>Carroll</u>	(State) <u>Ind.</u>
DATE REC'D BY LOCAL REG. <u>6/5/51</u>	REGISTRAR'S SIGNATURE <u>John A. Lohman</u>	24. FUNERAL DIRECTOR <u>C. M. Walz</u>	ADDRESS <u>Winfield, Ind.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06335

Reg. Dist. No. 30.1

1. PLACE OF DEATH- COUNTY <u>Washington County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Conococheague Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Maryland RFD #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gateway Convalescent Home</u>		STREET ADDRESS (If rural, give location) <u>Williamsport Md. RFD #2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Wesley</u>	(Last) <u>Corby</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>5</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 13 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>	9. AGE last birthday <u>95</u> yrs. <u>11</u> Months <u>24</u> Days
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Corby</u>		14. MOTHER'S MAIDEN NAME <u>Helen V. Kershner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-2172</u>	
17. INFORMANT AND ADDRESS <u>Mr. Clarence H. Straley RFD #2</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Mycocarditis Chronic

Antecedent cause(s)

(b) Anterior release

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1947, 19....., to June 5, 1951, that I last saw the deceased

alive on June 4, 1951, and that death occurred at 1 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>June 7 1951</u>	<u>Diverview Cemetery</u>	<u>Williamsport Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 7-1951</u>	<u>C. Lee McElroy</u>	<u>Albert L. Leaf</u>	<u>Williamsport Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690487

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06478

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND		COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and OR TOWN HAGERSTOWN)		LENGTH OF STAY (in 85 place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL				STREET ADDRESS 863 DEWEY AVE.		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) MITCHELL		(Middle) ANDREW		(Last) CORNWELL	
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, (Specify) MARRIED		4. DATE OF DEATH (Month) JUNE (Day) 8 (Year) 1951	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) STATIONARY ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY IRON WORKS		8. DATE OF BIRTH 5/13/1894		9. AGE last birthday 57 yrs. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME WILLIAM CORNWELL, William		14. MOTHER'S MAIDEN NAME EMMA GARDNER	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 214-09-4884		17. INFORMANT AND ADDRESS MRS. STELLA M. CORNWELL		HAG. MD.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Cerebral hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.

Antecedent cause(s)

(b) **Hypertension.**

?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 5, 1951** to **June 8, 1951**, that I last saw the deceased alive on **June 8, 1951**, and that death occurred at **3:40 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M.D.

Hagerstown, Maryland

June 9, 1951.

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 9, 1951

Phas H. Bowers

W. J. Norment, Hagerstown, Md.

583886

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06336
Dr. Hocklander

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown TOWN Hagerstown HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown TOWN Hagerstown STREET ADDRESS (If rural, give location) 109 South Mulberry Street	
3. NAME OF DECEASED (Type or Print) Lela (First) Edna (Middle) Cromer (Last)		4. DATE OF DEATH (Month) June (Day) 9 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 18, 1884
9. AGE last birthday 67 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Winfield Harbaugh		14. MOTHER'S MAIDEN NAME Ida F. Warner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS John E. Harbaugh			

18. MEDICAL CERTIFICATION		Interval Between Onset and Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Posterior Corneal occlusion		5 days	
Antecedent cause(s) (b) Hypertension Arterio Sclerotic Disease		P	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Diabetes mellitus			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 4, 1951, to June 8, 1951, that I last saw the deceased alive on June 8, 1951, and that death occurred at 1:55 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 6-12-1951	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Md.	(State)
DATE REC'D BY LOCAL REG. June 11, 1951	REGISTRAR'S SIGNATURE John E. Harbaugh	24. FUNERAL DIRECTOR Andrew K. Coffman, Hagerstown, Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

260X

RECEIVED

JUN 13 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06337

Reg. Dist. No. 3.03

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Clear Spring</u> TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Ernstville</u>		STREET ADDRESS (If rural, give location) <u>Washington County Home</u>	
3. NAME OF DECEASED (First) <u>Lewis</u> (Middle) <u>Ellsworth</u> (Last) <u>Curley</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10/2/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>220-10-3632</u>	
17. INFORMANT <u>Information from acquaintances</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Acute alcoholic narcosis

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>Had been on two weeks alcoholic binge</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title) DEPUTY MEDICAL EXAMINER

1159 Patomac

DATE SIGNED

23. BURIAL, CREMATION REMOVAL <u>At home</u>	DATE THEREOF <u>6/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>June 5/51</u>	REGISTRAR'S SIGNATURE <u>J.W. Murray</u>	24. FUNERAL DIRECTOR <u>A.H. Rowland</u>	ADDRESS <u>Clear Spring, Md.</u>

9700W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06338

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN STREET ADDRESS (If rural, give location) <u>34 N. Locust</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harry</u>	(Middle) <u>L</u>	(Last) <u>Daley</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>22</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DECEASED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-15-1882</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>22</u> Hours <u>51</u> Min.	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Oscar Daley</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Stouffer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-09-4115</u>		17. INFORMANT AND ADDRESS <u>Mrs. H.L. Daley, 34 N. Locust City</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Apoplexy - Paroxysms

INTERVAL BETWEEN ONSET AND DEATH

6 days

Antecedent cause(s)

(b)

Arterio-sclerosis - Gen1 year

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED	HOW DID INJURY OCCUR?			
	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				

22. I hereby certify that I attended the deceased from June 16, 1951, to June 22, 1951, that I last saw the deceasedalive on June 22, 1951, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>June 25, 1951</u>	<u>Rest Haven</u>	<u>Hagerstown</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 25, 1951</u>	<u>[Signature]</u>	<u>Fred W. Kraiss</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06339

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Naquetons</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural P.D.H.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Mauginsville Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>MICHAEL EDWARD Safflemyer</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 19, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>46</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Warren Edward Safflemyer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Elene Horne</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mrs. Warren E. Safflemyer</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3³⁶</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Respiratory failure - central origin</u>		
Antecedent cause(s) (b) <u>Prematurity - 30 wks preg.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6-18-51, 19....., to....., 19....., that I last saw the deceased alive on 6-18, 1951, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 20/1951</u>	<u>Rest Haven Cemetery</u>	<u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 20/1951</u>	<u>W. K. H. Sowers</u>	<u>Rest Haven Funeral Chapel</u>	<u>Hagerstown Md.</u>	

206191262 321

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 22 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06340

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A. Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Danville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eugene</u>	(Middle) <u>Summers</u>	(Last) <u>Dove</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 17, 1888</u>
9. AGE last birthday <u>63</u> yrs.		If under 1 year Months/ Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Joseph Dove</u>		14. MOTHER'S MAIDEN NAME <u>? Elenora Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Encephalomalacia</u>		<u>2 yrs.</u>
Antecedent cause(s) (b) <u>Generalized arterio-sclerosis</u>		<u>same yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Syphilitic Aneurysm of ascending aorta</u>		<u>same yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>(X-ray findings)</u>	20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 3....., 1950., to June 3....., 1951., that I last saw the deceased alive on June 3....., 1951., and that death occurred at 6:35 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>buried</u>	<u>June 5/51</u>	<u>West View Church Cem</u>	<u>West View</u>	<u>MD</u>
DATE RECD BY LOCAL REG	REGISTERER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/4/51</u>	<u>J. H. Clayton</u>	<u>J. C. Hardisty + Son</u>	<u>Danville</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1951

BUREAU N. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

06341

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>25 E Potomac Street</u>		STREET ADDRESS (If rural, give location) <u>23 E Potomac Street</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Newton</u>	<u>Kurtz</u>	<u>Downs</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>June 3</u>	<u>1951</u>		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>April 13 1866</u>
9. AGE last birthday	If under 1 year	If under 24 hrs.	
<u>85 yrs.</u>	Months <u>1</u> Days <u>20</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Mail Messenger</u>		<u>U.S. Postal Ser.</u>	<u>Downsville Md</u>
12. CITIZEN OF WHAT COUNTRY?		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Christopher Downs</u>		<u>Anna Rebecca Curfman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
<u>NO</u>		<u>None</u>	<u>Williamsport Md.</u> <u>Norris Downs 25 E Potomac Street</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

48 hours48 hrs.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 1, 1951, to June 3, 1951, that I last saw the deceased alive on June 3, 1951, and that death occurred at 4 A. m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS

Buried
June 5 1951
Riverview Cemetery
Williamsport Maryland
June 5 - 1951
E Lee McElroy
Albert L Leaf #7 Church Street

MARGIN RESERVED FOR BINDING

VS. A-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632808

RECEIVED

JUN 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

06342

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PENMAR</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>PENMAR</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>355 Yale Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Katherine</u> <u>Doyle</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 28</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAY 22 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs.
13. FATHER'S NAME <u>JAMES H. DOYLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY HENRY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr. Frank S. Dettmerich, Balt. Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>		<u>1/2 hour</u>
420.1 Antecedent cause(s) (b) <u>Arteriosclerosis Cardiovascular disease</u>		<u>Unknown</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 June, 1951, to 28 June, 1951, that I last saw the deceased alive on 28 June, 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>Robert A. Penmar, MD</u>	(Degree or title)	ADDRESS <u>Blue Ridge Summit, Penna.</u>	DATE SIGNED <u>June 28 1951</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>6/30/1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>6-30-51</u>	REGISTRAR'S SIGNATURE <u>Mr. Joseph W. Murray</u>	24. FUNERAL DIRECTOR <u>Geo. A. Farley</u>	ADDRESS <u>Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 5 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Cohen

06343

CERTIFICATE OF DEATH

Reg. Dist. No. 801

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>44 West Salisbury St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u> STREET ADDRESS (If rural, give location) <u>44 West Salisbury St.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	<u>ELSIE</u>	<u>ALMEDA</u>	<u>DURBORAW</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Mar 9 1885</u>
9. AGE last birthday	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>66</u>	<u>Housewife</u>	<u>Own Home</u>	<u>Hagerstown Md</u>
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service)
<u>USA</u>	<u>Daniel Rice</u>	<u>Mary E. Potts</u>	<u>No</u>
16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS	18. MEDICAL CERTIFICATION <u>Williamsport Md.</u>	
<u>None</u>	<u>William T. Durboraw</u>		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause	(a) <u>Adeno carcinoma Stomach</u>	INTERVAL BETWEEN ONSET AND DEATH
46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Osteogenic Sarcoma - Rt femur</u>	<u>duration - unknown</u>
	(c)	<u>unknown</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Chronic auricular fibrillation -</u>	12. AUTOPSY?
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<u>none</u>	<u>none</u>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
<u>SUICIDE</u>	<u>INJURY</u>	(COUNTY)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY	m.	

22. I hereby certify that I attended the deceased from May 22, 1951, to June 10, 1951, that I last saw the deceased alive on June 10, 1951, and that death occurred at 10:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Archibald Cohen M.D. Clear Spring Md. 6-11-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/12/51</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown Wash. co.</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/11/51</u>	<u>E Lee McElroy</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

06344

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade Md.</u>	
TOWN <u>Life</u>		TOWN <u>Cascade Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cascade Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles E. Flaughner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 1, 1951</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Nov. 16, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>	
11. BIRTHPLACE (State or foreign country) <u>Cascade Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Flaughner</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Nicholas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Sylvia Wastler, Cascade Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cannara & Clusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Not While m. Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-10, 1940 to 6-1, 1951 that I last saw the deceasedalive on 5-31, 1951, and that death occurred Cascade Md. from the causes and on the date stated above.SIGNATURE Harvey B. Bridges ADDRESS Blue Ridge Summit Pa. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial 6/3/51 Bethel C. Cascade Washington Md.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

June 2-51 Geo. H. Engman Walter G. Grove, Waynesboro Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06345

30/

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Williamsport</u> TOWN <u>Williamsport</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>131 S. Prospect St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>REBECCA</u>	(Middle) <u>HOLLINGSWORTH</u>	(Last) <u>FRENCH</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>7</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 2 1861</u>
9. AGE last birthday <u>89</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George French</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth R. Hollingsworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Kate Dawson Hagerstown Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Endocarditis - Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

10 yrs.Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Rheumatic Endocarditis20 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 20 yrs., 19....., to....., 19....., that I last saw the deceased alive on May 31, 1957, and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-11-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/11/51</u>	REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUN 15 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Hirshman

Reg. Dist. No. 302

06346

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>24 hrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>113 W. Howard St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM WESTFALL GARRETT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 23 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/20/1889</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Industry</u>	11. BIRTHPLACE (State or foreign country) <u>Needmore, W. Va.</u>
13. FATHER'S NAME <u>George Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>215-28-2215</u>	
17. INFORMANT AND ADDRESS <u>Charles Garrett Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			<u>1 wk</u>
Antecedent cause(s) (b) <u>Arteriosclerosis - Generalized</u>			<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>June 23, 1957</u> to <u>June 24, 1957</u> , that I last saw the deceased alive on <u>June 24, 1957</u> , and that death occurred at <u>7:00</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>W. H. Hagerman</u>		DATE SIGNED <u>June 25, 1957</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/29/57</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>
DATE REC'D BY LOCAL REG. <u>June 26, 1957</u>		REGISTRAR'S SIGNATURE <u>Charles H. Brown</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

390377

RECEIVED
JUN 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06347

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Sharpsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frisby</u>	(Middle) <u>Tilden</u>	(Last) <u>Gray</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>10</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 18, 1886</u> 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Process Stair</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Antietam-Wash.-Maryland</u>
13. FATHER'S NAME <u>George Gray</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-1278</u>	
		17. INFORMANT AND ADDRESS <u>Mrs. Mary Gray--Rural Sharpsburg, Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute coronary thrombosis
(b) arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

4 days5 Yrs?II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/1/51, 19....., to 6/10/51, 19....., that I last saw the deceased alive on 6/10/51, 19....., and that death occurred at 10:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/13/51</u>	<u>Mt. View</u>	<u>Sharpsburg, Md</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>June 11, 1951</u>	<u>[Signature]</u>	<u>R. I. Earnshaw--Keedysville, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 446

632636



BUREAU A. S.

JUN 18 1951

RECEIVED

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY <u>Loudon</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lovetttsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cor. Mill St & East Baltimore St</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Edna</u> (First) <u>Pauline</u> (Middle) <u>Green</u> (Last)	4. DATE OF DEATH <u>June 28</u> (Month) <u>1951</u> (Year)		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> (Specify)	8. DATE OF BIRTH <u>13 March 1916</u>
9. AGE last birthday <u>35</u> yrs.		10. If under 1 year Months <u>5</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>		12. CITIZEN OR WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Howard Barbehenn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Josephine Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Vera Barbehenn</u>		18. MEDICAL CERTIFICATION <u>Martinsburg W. Va.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
819.5 Immediate cause (a) <u>Fractured Skull</u>			<u>5 min.</u>
Antecedent cause(s) (b) <u>Hæmorrhax</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hæmorrhage & Shock</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office hldg., etc.) <u>INCURRY</u>		(CITY OR TOWN) (COUNTY) (STATE) <u>E. Balto. St. Hagerstown Wash. Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-28-51 4:20 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Auto Collision</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>S. Robert Wells MD.</u>		DEPUTY MEDICAL EXAM. <u>Hagerstown, Md.</u> DATE SIGNED <u>6.28.51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/2/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Gettysburg Adams Pa.</u>	
DATE REC'D BY LOCAL REG. <u>June 30, 1951</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1961
BUREAU 7.8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3210

06349

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemont</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Christian</u>	(Middle) <u>G.</u>	(Last) <u>Grotz</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>June 7, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Labor</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johannes Grotz</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Schray</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Elizabeth Grotz, Edgemont Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension & Atherosclerosis

years.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1950, to 16 June, 1951, that I last saw the deceased

alive on 16 June, 1951, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE John Dean Wilson M.D. ADDRESS Smithsburg, Md. DATE SIGNED 6/18/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/18/51</u>	<u>Smithsburg</u>	<u>Smithsburg</u>	<u>Washington Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>June 18-51</u>	<u>Geo. W. Ferguson</u>	<u>Walter J. Lowe, Waynesboro Pa.</u>		

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

THE STATE DEPARTMENT OF JUSTICE

GENERAL INVESTIGATIVE DIVISION

WASHINGTON, D. C.

EXHIBIT

UNITED STATES OF AMERICA

W

EXHIBIT

BUREAU V. S.

JUN 21 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06350

Reg. Dist. No. 304

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) HANCOCK		CITY (If outside corporate limits, write RURAL and give nearest town) HANCOCK	
TOWN HANCOCK		TOWN HANCOCK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street		STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or Print) Mary (First) Amelia (Middle) Hahne (Last)		4. DATE OF DEATH June 9, 1951 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH May 8, 1868
9. AGE last birthday 83 yrs.		10. CITIZEN OF WHAT COUNTRY? A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Annie Lawver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Myrtle B. Heller- Hancock, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage			
Antecedent cause(s) (b) Pulmonary failure			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Failure			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 4, 1951, to June 9, 1951, that I last saw the deceased alive on June 9, 1951, and that death occurred at 11:45 m., from the causes and on the date stated above.

SIGNATURE J. A. Heller (Degree or title) ADDRESS Hancock Md 6/11/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE June 12-51	NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	LOCATION (City, town, or county) Cumberland, Md.	(State)
DATE REC'D BY LOCAL REG. 6-12-51	REGISTRAR'S SIGNATURE J. A. Heller	24. FUNERAL DIRECTOR	ADDRESS	

720826 Clear Spring, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06351

Reg. Dist. No. 302

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>	LENGTH OF STAY (in this place) <u>38 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1004 Main Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lily</u> (First) <u>Rebecca</u> (Middle) <u>Hamilton</u> (Last)	4. DATE OF DEATH (Month) <u>6/8</u> (Day) <u>51</u> (Year) <u>19</u>	5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>4/26/1879</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>unk.</u>	
14. MOTHER'S MAIDEN NAME <u>unk.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY No. <u>unk.</u>		17. INFORMANT AND ADDRESS <u>Victor Hamilton Hagerstown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

10 days

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 28, 1951, to June 8, 1951, that I last saw the deceased

alive on June 8, 1951, and that death occurred at 7:15 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify) Burial

DATE THEREOF 6/11/51

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) Hagerstown, Md.

(State)

DATE REC'D BY LOCAL REG. June 11, 1951

REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR F. W. Kraiss

ADDRESS Hagerstown, Md.

RECEIVED

JUN 13 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 316

06352

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Keedysville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville</u> STREET ADDRESS (If rural, give location) <u>Main</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
	<u>John</u>	<u>Henry</u>	<u>Hammond</u>	<u>June 30</u>	<u>1951</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days If under 24 hrs. Hours Min.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>11-29--1873</u>	<u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Janitor</u>		<u>School</u>	<u>Downsville, Md</u>		<u>U. S.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<u>William K. Hammond</u>			<u>Wilma H. Guyer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS		
<u>No</u> (If yes, give war or dates of service)		<u>None</u>	<u>Mrs Mary Long--Keedysville, Md</u>		

13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fernicious Anemia 7 Mo. 12 Da

540.0 Antecedent cause(s) (b) Gastric Ulcer " "

117a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 18, 1950, to June 30, 1951, that I last saw the deceased alive on June 30, 1951, and that death occurred at 11:30 P., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>July 3, 1951</u>	<u>Lutheran</u>	<u>Bakersville, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>July 3 51</u>	<u>R. I. Earnshaw</u>	<u>R. I. Earnshaw--Keedysville, Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

770888



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06353
 Dr Wells
 Reg. Dist. No. 302

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) Washi ngton OR Hagerstown TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. county Hospital MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown OR TOWN STREET ADDRESS (If rural, give location) 412 West Washington St.	
3. NAME OF DECEASED (Type or Print) (First) SAMANTHA (Middle) CEARFOSS (Last) HARNE		4. DATE OF DEATH June 29 1951 (Month) (Day) (Year)	
5. SEX female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Aug 20 1905
9. AGE last birthday 45 yrs.		10. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co. Md	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer- Caskey Baking Co		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lucius Cearfoss		14. MOTHER'S MAIDEN NAME Katherine Bonebrake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 214-09-2148	
17. INFORMANT AND ADDRESS William E. Harne		18. MEDICAL CERTIFICATION 412 W. Wash. St.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Arterio-sclerotic coronary heart disease Antecedent cause(s) (b) acute coronary occlusion Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? Dropped dead at work

22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>	
SIGNATURE S. Robert Wells MD DEPUTY MEDICAL EXAMINER ADDRESS 115 N. Patomac St. Hagerstown, Md. DATE SIGNED 6/29/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 7-1-51	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery LOCATION (City, town, or county) Hagerstown Md. (State)
DATE REC'D BY LOCAL REG June 30, 1951 REGISTRAR'S SIGNATURE L. K. H. Bowers	24. FUNERAL DIRECTOR Andrew K. Coffman ADDRESS Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06354

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boonsboro</u>	LENGTH OF STAY (in this place) <u>19 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Myersville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>ELZA</u> (Middle) <u>Harshman</u> (Last)		4. DATE OF DEATH <u>June 15</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 28-1896</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Fred Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Harshman</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ann Neff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Estel Harshman - Boonsboro Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardio-Renal - Vascular disease

INTERVAL BETWEEN ONSET AND DEATH

6 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 1944, to June 15, 1951, that I last saw the deceased

alive on June 14, 1951, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE: J. E. Harp M.D. ADDRESS Woodlawn DATE SIGNED June 15-51

23. BURIAL, CREMATION (REMOVAL) (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 17/1951</u>	<u>Grossnickles</u>	<u>M. Myersville, Fredco. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 16/1951</u>	<u>John W. Best</u>	<u>Paul F. Bitts</u>	<u>Myersville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06355

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>59 W. Bethel St.</u>		STREET ADDRESS (If rural, give location) <u>59 W. Bethel St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>Romeo</u> (Last) <u>Herbert</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8/5/1891</u>
9. AGE last birthday <u>59</u> yrs.		If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Employer</u>	
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>David Hervert</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Gray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>old war</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Pearl Jones 59 W. Bethel St.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) arterio-sclerotic coronary heart disease
 420.0 Antecedent cause(s) disease
 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Acute coronary occlusion

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m. INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Note: Fell over dead on porch

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

DEPUTY MEDICAL EXAMINER

DATE SIGNED

S. Robert Wells, M.D.

WASH. CO., MD.

115 N. Potomac St. Hagerstown, Md.

6/6/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF
6-7-51

NAME OF CEMETERY OR CREMATORY
National Cemetery

LOCATION (City, town, or county)
Sharpsburg, Md.

(State)

DATE REC'D BY LOCAL REG.
June 7, 1951

REGISTRAR'S SIGNATURE
Shash H. Zowers

24. FUNERAL DIRECTOR

ADDRESS

John R. Watson Jr. 24 W. Bethel St. Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A T

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06356

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH - COUNTY WASHINGTON		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town) ROHRSVILLE		COUNTY WASHINGTON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAIN ST.		CITY (If outside corporate limits, write RURAL and give nearest town) ROHRSVILLE	
LENGTH OF STAY (in this place) LIFE		STREET ADDRESS (If rural, give location) MAIN ST.	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
GRACE	ELIZABETH	HOVERMALE	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY-30-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE last birthday 51-0-22 yrs.
11. BIRTHPLACE (State or foreign country) ROHRSVILLE WASH. Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL J. MULLENDARE		14. MOTHER'S MAIDEN NAME LIZZIE STINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS WM. H. HOVERMALE ROHRSVILLE MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Acute Pulmonary Edema.****Sudden**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Rheumatic Heart Disease with Auricular fibrillation Mitral Stenosis.****1Mo. 19da.**II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 3**, 19**51**, to **June 22**, 19**51**, that I last saw the deceased alive on **June 14**, 19**51**, and that death occurred at **10.10 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

ENCRYPTMENT

JUNE-25-1951**BOONSBORO****MAUSOLEUM****BOONSBORO WASH. Co. MD.**

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

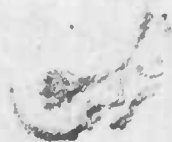
ADDRESS

June 25-1951 Katherine Degenhart**WM. F. BAST AND SONS BOONSBORO MD.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415



RECEIVED
JUN 26 1961
BUREAU V. J.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06357

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 341 N Jonathans St.		STREET ADDRESS (If rural, give location) 341 N Jonathans St.	
3. NAME OF DECEASED (Type or Print) Robert Edwin Jackson		4. DATE OF DEATH 6 27 19 51	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 5-29-1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Furniture, Co.	11. BIRTHPLACE (State or foreign country) Sharpsburg, Maryland
13. FATHER'S NAME Robert Sherman Jackson		14. MOTHER'S MAIDEN NAME Edna Virginia King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 153 W North St.	
		17. INFORMANT AND ADDRESS Mrs. Edna V. Jackson, Hagerstown, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 27, 1951, to June 27, 1951, that I last saw the deceasedalive on June 27, 1951, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	6-30-1951	Tolson Chapel	Sharpsburg, Maryland	

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 30, 1951Robert H. BowersJohn R. Watson Jr. Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. At 5

RECEIVED
JUL 3 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06358

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1020 Corbett St.</u>		STREET ADDRESS (If rural, give location) <u>1020 Corbett St.,</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ida</u>	(Middle) <u>Mae</u>	(Last) <u>Jacobs</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>7-24-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Hancock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morris Snook</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Mort</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Clayton Jacobs, 1020 Corbett St</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

1/2 hr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio sclerosis (generalized)10 yrs +(c) Diabetes Mellitus10 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. ny

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct, 1936, to 24 June, 1951, that I last saw the deceasedalive on 24 June, 1951, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>6-27-51</u>	<u>Rest Haven</u>	<u>Hagerstown, Md.</u>	

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 26, 1951</u>	<u>Charles H. Havers</u>	<u>Fred W. Kraiss</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

4/10/51

Chas

4/51

RECEIVED
JUN 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06359

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Was. County Hospital</u>		STREET ADDRESS (If rural, give location) <u>118 N. Locust</u>	
3. NAME OF DECEASED (First) <u>Gerald</u> (Middle) <u>Donald</u> (Last) <u>Kauffman Jr.</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 8, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9. AGE last birthday <u>1</u> yr. If under 1 year Months <u>1</u> Days <u>1</u> If under 24 hrs. Hours <u>1</u> Minutes <u>1</u>
13. FATHER'S NAME <u>Gerald D. Kauffman Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Hershey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Gerald D. Kauffman Sr. Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Respiratory failure, probably central</u>		<u>1-10 min</u>	
Antecedent cause(s) (b) <u>and due to intracranial hemorrhage</u>		<u>1-10 min</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Prolonged 2nd stage of labor</u>		<u>6 1/2 hrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>June 8, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>6-8-51</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>6-8-51</u>		HOW DID INJURY OCCUR? <u>3:30 a</u>	

22. I hereby certify that I attended the deceased born 6-8-51, to 1320 W. Wash St. Hagerstown, 1951, that I last saw the deceased alive on 6-8, 1951, and that death occurred at 3:30 a m., from the causes and on the date stated above.

SIGNATURE Robert F. Keader MD ADDRESS 1320 W. Wash St. Hagerstown DATE SIGNED 6-9-51

23. BURIAL CREMATION REMOVAL (Specify) Burial DATE THEREOF June 9, 1951 NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery LOCATION (City, town, or county) Hagerstown Md.

DATE REC'D BY LOCAL REG. June 9, 1951 REGISTRAR'S SIGNATURE Walter H. Powers 24. FUNERAL DIRECTOR Scott F. Minnich & Son ADDRESS Hagerstown Md.

206081261406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06360

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>10 N. Vermont Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS <u>Williamsport Maryland</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Inez</u>	<u>Frances</u>	<u>Kerns</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Dec. 19 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Housestress</u>		<u>Laundry</u>	<u>58</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Park Head Md.</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Lewis Myers</u>		<u>Lucy Wiland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
<u>No</u>		<u>217-16-2952</u>	<u>Mr. George Nelson Kerns Williamsport</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

5 Days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 5/3/51 19....., to 6/5/51 19....., that I last saw the deceased alive on 6/5/51 19....., and that death occurred at 9:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 8 1961</u>	<u>Greenlawn Cemetery</u>	<u>Williamsport Md.</u>	

DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 8-1951</u>	<u>Thasht Bowen</u>	<u>Albert L. Leaf Williamsport Md.</u>	

Rec'd from Mrs. McGrooy 6/12/51

643846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 14 1951
BUREAU V. S.

6-21-51 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06361

CERTIFICATE OF DEATH

Reg. Dist. No. 3.45

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NORTH MAIN ST.</u>		STREET ADDRESS (If rural, give location) <u>NORTH MAIN STREET.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>HUBERT</u> (Last) <u>KNODE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE - 8 - 1951</u>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>APRIL - 24 - 1868</u> 9. AGE last birthday <u>83-1-14</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE OPERATOR - RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. Co. Md.</u>	
13. FATHER'S NAME <u>SAMUEL KNODE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>KATHARINE LANE</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>MRS. KATHARINE KNODE BOONSBORO MD.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lobar Pneumonia

Antecedent cause(s)

(b) II Arterio Sclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) II Arterial Hypertension

INTERVAL BETWEEN ONSET AND DEATH

12 days3 yrs. 3 mos" "

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.
(6-21-51 - ams)

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 12, 1948, to June 8, 1951, that I last saw the deceasedalive on June 7, 1951, and that death occurred at 1:30 a.m. on the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John H. BastM.D.Boonsboro Md.6/9/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JUNE 9 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	LOCATION (City, town, or county) <u>BOONSBORO WASH. Co. MD.</u>	(State)
DATE REC'D BY LOCAL REG <u>June 9, 1951</u>		REGISTRAR'S SIGNATURE <u>John H. Bast</u>	24. FUNERAL DIRECTOR <u>WM. E. BAST AND SONS BOONSBORO MD.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

470 746

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06362

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Monongalia</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Huvetts Croos Roads</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Morgantown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On Highway</u>		STREET ADDRESS (If rural, give location) <u>244 McLane Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ivy</u>	(Middle) <u>Blanche</u>	(Last) <u>Krouse</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>24</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-12-1893</u>
9. AGE last birthday <u>57</u> yrs.		If under 1 year: Months <u>0</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Smithton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tom Hyland</u>		14. MOTHER'S MAIDEN NAME <u>Barton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>235-52-1823</u>	
17. INFORMANT AND ADDRESS <u>Evaline K. McCutcheon</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 420.1 Antecedent cause(s) acute coronary occlusion
 Diseases or conditions, if any, giving rise to the above cause (b) 94a stating the underlying cause last
 (c)

12hrs

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Sudden death enroute to Hospital</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)
 DEPUTY MEDICAL EXAM.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>6-25-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Davidson Bros. Fun.. Home</u>	LOCATION (City, town, or county) <u>Morgantown, W. Va.</u>	(State)
---	----------------------------------	---	---	---------

DATE REC'D BY LOCAL REG. June 24, 1951 REGISTRAR'S SIGNATURE [Signature]

24. FUNERAL DIRECTOR
 C. M. Suter & Sons, Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 26 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06363
 Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Eckhart</u> COUNTY <u>Allegany</u> md.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u> (Middle) <u>Cecil</u> (Last) <u>Lancaster</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>25</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 7, 1900</u>
9. AGE last birthday <u>51</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal miner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Coal miner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>John L Lancaster</u>	14. MOTHER'S MAIDEN NAME <u>Mary Chaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>214-01-3753</u>	17. INFORMANT <u>Mrs. Caroline Griffith (Barton md)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Asphyxia - by drowning</u>		
(b) Antecedent cause(s) <u>183</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Hancock Wash.</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>md</u>
TIME (Month) (Day) (Year) (Hour) <u>6 15 51</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Found in Potomac River</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>J. Robert Wells M.D.</u>		DATE SIGNED <u>6-25-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-29-51</u>
NAME OF CEMETERY OR CREMATOR <u>Eckhart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart Allegany md</u>
DATE REC'D BY LOCAL REG. <u>6-27-51</u>	REGISTRAR'S SIGNATURE <u>J A Keller</u>	24. FUNERAL DIRECTOR <u>Charles R Bart</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

650216



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06364

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>104 Cypress St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph I Lyon</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6 27 51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-25-1891</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Engineer</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
14. FATHER'S NAME <u>Jacob Lyon</u>		15. MOTHER'S MAIDEN NAME <u>Minnie -----</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <u>219-12-2191</u>	
18. INFORMANT AND ADDRESS <u>Mrs. Rena Kaplan Lyon</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Coronary thrombosis4 days

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.no

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from JUN. 23, 1951, to JUN. 27, 1951, that I last saw the deceased alive on JUN. 27, 1951, and that death occurred at 8:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REBURYAL (Specify)		DATE OF BURIAL, CREMATION, REBURYAL		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Reburial</u>		<u>6-29-51</u>		<u>Hebrew Cemetery</u>		<u>Halfway Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 29, 1951</u>		<u>Brashear Bowers</u>		<u>Fred W. Kraiss</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06365 305

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>	
TOWN <u>SAN MAR.</u>		TOWN <u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FAHRNEY MEMORIAL HOME</u>		STREET ADDRESS (If rural, give location) <u>NEAR MIDDLETOWN</u>	
3. NAME OF DECEASED (First) <u>ESTA</u> (Middle) <u>F.</u> (Last) <u>MSBRIDE</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>APRIL - 27 - 1869</u> 82-1-5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>NEAR MIDDLETOWN FRED. CO. MD.</u>
13. FATHER'S NAME <u>HENRY C. MSBRIDE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET SICKLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>ELSWORTH, MSBRIDE 412 CROYDON ROAD</u>		18. MEDICAL CERTIFICATION <u>BALTIMORE - 12 - MD.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis -

Antecedent cause(s) (b) 422.2 93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 10, 1950, to June 2, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Boonsboro</u>	DATE SIGNED <u>6/5/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>June 5 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>LOCUST VALLEY CEMETERY</u>	LOCATION (City, town, or county) (State) <u>NR. BURKETSVILLE MD.</u>
DATE REC'D BY LOCAL REG. <u>June 5, 1951</u>	REGISTRAR'S SIGNATURE <u>John W. Best</u>	24. FUNERAL DIRECTOR <u>WM. E. BAST AND SONS</u>	ADDRESS <u>Boonsboro MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06366 302

1. PLACE OF DEATH - COUNTY <u>Leitersburg, Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Leitersburg, Washington</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg, Washington County</u>	
TOWN <u>Leitersburg, Md</u>		TOWN <u>Leitersburg, Washington County</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Raymond</u> (Last) <u>McClellan</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>9</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 7, 1887</u>
9. AGE last birthday <u>64</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick County, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13. FATHER'S NAME <u>George H. McClellan</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Boone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Clara M. Foutz</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arterio sclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

10 yrs +

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March, 1946, to 9 June, 1951, that I last saw the deceasedalive on 3 June, 1951, and that death occurred at 4:30 P. m., from the causes and on the date stated above.SIGNATURE J. J. Lusby

(Degree or title)

ADDRESS 230 N. PrimmDATE SIGNED 11 June 51

23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>June 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	LOCATION (City, town, or county) <u>Leitersburg, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>June 11, 1951</u>	REGISTRAR'S SIGNATURE <u>Thos. H. Gowers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss, Hagerstown, Md</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED

JUN 13 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06367

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>229 1/2 N. Jonathan St.</u>		STREET ADDRESS <u>229 1/2 N. Jonathan St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Julia</u>	(Middle) <u>none</u>	(Last) <u>Morris</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>5-3-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Birmingham, Ala.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Emily Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Emily O. Dudley, Hagerstown</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Vascular Hypertension</u>			
Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>S. Robert Wells, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>115 N. Potomac St. Hagerstown, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-27-51</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>June 27, 1951</u>		REGISTRAR'S SIGNATURE <u>John R. Watson</u>	24. FUNERAL DIRECTOR <u>John R. Watson Jr. Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

116

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clearspring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clearspring</u> STREET ADDRESS (If rural, give location) <u>Main St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>OTHO</u>	(Middle) <u>PRESTON</u>	(Last) <u>MYERS</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/12/1882</u>
9. AGE last birthday <u>68</u> yrs.	4. DATE OF DEATH <u>June 6</u>	(Day) <u>6</u>	(Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>David Myers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Norman W. Myers, Harrisburg, Penna.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis &

INTERVAL BETWEEN ONSET AND DEATH

1 year

Antecedent cause(s)

(b)

Occlusion

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensive Sclerosis5 years11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1950, to June 6, 1951, that I last saw the deceasedalive on June 4, 1951, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 8, 1951J. W. MurrayAndrew K. CoffmanHagerston Md.

290 679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06369

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>20 E. Washington St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lynwood</u> (Middle) <u>M</u> (Last) <u>Newcomer</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 3 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 13, 1916</u>
9. AGE last birthday <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patrolman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles A. Newcomer</u>		14. MOTHER'S MARRIAGE NAME <u>Josephine Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I. 5 yrs.</u>		16. SOCIAL SECURITY NO. <u>217-10-0636</u>	
17. INFORMANT <u>Mrs. Janet J. Newcomer</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>914.5</u> <u>Electrocution</u>		<u>3 hrs</u>	
(b) <u>Antecedent cause(s)</u> <u>193</u> <u>asphyxia by electrocution</u>			
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Lincoln Ave.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 - 3 - 51 9:25</u>		HOW DID INJURY OCCUR? <u>Came in contact with high tension wire</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
SIGNATURE <u>S. Police & Wells, M.D.</u>		DATE SIGNED <u>6.4.51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cnd.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>James S. 1951</u>		24. FUNERAL DIRECTOR <u>W. J. Norment</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

773936

BUREAU V. S.

JUN 7 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06370

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Magnolia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie State Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Jacob</u> <u>Henry</u> <u>Norton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>1</u> <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 8, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	9. AGE last birthday <u>49</u> yrs. If under 1 year 1 month 1 day 1 hour 1 min.
11. BIRTHPLACE (State or foreign country) <u>Harford Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob H. Norton</u>		14. MOTHER'S MAIDEN NAME <u>Martha Waters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>216-07-1959</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Squamous cell Carcinoma of esophagus c metastasis.</u>		<u>~ 3 mo</u>
Antecedent cause(s)	(b) <u>Malnutrition</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?	
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from May, 1955, to June, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE Apel G. Pava, M.D. ADDRESS Ritchie State Hosp, Cascade, Md DATE SIGNED 6/1/57

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/5/57</u>	<u>Asbury</u>	<u>Joppa, Harford Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 7-57</u>	<u>Geo. W. Ferguson</u>	<u>Howard K. McGowan & Son</u>	<u>abingdon Md 970506</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AT

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

06371

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>210 West Washington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Carrie</u>	(Middle) <u>E.</u>	(Last) <u>Pearl</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-27-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>52 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Sottlemeyer</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Whitmore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Charles A. Pearl, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>	<u>5-25-51</u>
Antecedent cause(s) (b) <u>Hypertension, Arterio. Vascular Disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 1948, to June 2, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE <u>Ludney Noverson</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Hagerstown Md</u>	DATE SIGNED <u>6-2-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-5-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REG. <u>June 5, 1951</u>	REGISTRAR'S SIGNATURE <u>W. H. Sowers</u>	24. FUNERAL DIRECTOR <u>C. M. Suter & Sons, Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 416

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06372 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Maugansville		CITY (If outside corporate limits, write RURAL and give nearest town) Maugansville	
TOWN Maugansville		TOWN Maugansville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.		STREET ADDRESS Main St. (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Mamie Flook		4. DATE OF DEATH 6 - 17 51	
6. SEX female		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	
6. COLOR OR RACE white		8. DATE OF BIRTH 5-7-1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9. AGE last birthday 77 yrs. If under 1 year Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Middletown, Md.	
13. FATHER'S NAME Jonas T. Flook		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME Annie M. Shoemaker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --	
16. SOCIAL SECURITY NO. --		17. INFORMANT AND ADDRESS George W. Petre, Maugansville, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

(b)

Arteriosclerotic Heart Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-1-1955, to 6-17, 1955, that I last saw the deceased alive on 6-17, 1955, and that death occurred at 1 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-20-51	NAME OF CEMETERY OR CREMATORY Long Meadows Church	LOCATION (City, town, or county) Paramount, Md.	(State)
DATE REC'D BY LOCAL REG June 20, 51	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 44

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06373

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Boonesboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Guilford Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>334 Mitchell Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>Franklin</u> (Middle) <u>Price</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Apr. 3-1883</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Ridgeway W.Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Price</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Swartz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>717-07-9379</u>	
17. INFORMANT AND ADDRESS <u>Mr. Harold L. Price</u> <u>Hag. Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arterio-sclerotic Cardio Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH
15 yr

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify) W

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY none

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1951, to June 21, 1951, that I last saw the deceased

alive on 6 May, 1951, and that death occurred at 7:40p m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

REASON (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 5, 1951

John H. East

Scott F. Minnich & Son

Hag. Md.

203506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 11 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. William Layman

Reg. Dist. No. 302

06374

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>1 month</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Cty. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>304 S. Mulberry St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Ann Pruett</u>		4. DATE OF DEATH <u>June 14, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Mar 12 - 1951</u>
9. AGE last birthday <u>1</u> yrs. <u>1</u> Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Pruett</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Dinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Thomas E. Pruett</u>		18. MEDICAL CERTIFICATION <u>304 S. Mulberry St</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>491X</u> <u>107</u> <u>Branchial pneumonia</u>		<u>2 days</u>	
Antecedent cause(s) (b) <u>107</u> <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Prematurity</u>		<u>33 days</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1951</u> , to <u>June 14, 1951</u> , that I last saw the deceased alive on <u>June 13, 1951</u> , and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. J. Layman, M.D.</u>		DATE SIGNED <u>Agreement by June 14, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>6-15-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 15, 1951</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman, Hagerstown, Md.</u>	

26511202322

VS. LAB

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

06375

1. PLACE OF DEATH- COUNTRY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BREATHEDSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BREATHEDSVILLE (RURAL)</u>	
TOWN <u>BREATHEDSVILLE</u>		TOWN <u>BREATHEDSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BOONSBORO MD. R. 1.</u>		STREET ADDRESS (If rural, give location) <u>BOONSBORO MD. ROUTE 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>OLIVE</u> (Middle) <u>G</u> (Last) <u>REID</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY-8-1891</u>
9. AGE last birthday <u>70-1-9</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BREATHEDSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. McNAMEE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>WM. D. McNAMEE Boonsboro MD R. 1</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b) Arterial Sclerotic Heart Disease.?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 15, 1951, to June 17, 1951, that I last saw the deceasedalive on June 15, 1951, and that death occurred at 8.00A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>JUNE 19-1951</u>	NAME OF CEMETERY OR CREMATORY <u>ST. MARKS CEMETERY</u>	LOCATION (City, town, or county) <u>LAPPANS WASH. CO. MD</u>	(State)
DATE REC'D BY LOCAL REG. <u>June 19, 1951</u>	REGISTRAR'S SIGNATURE <u>John D. Bast</u>	24. FUNERAL DIRECTOR <u>WM. F. BAST AND SONS</u>	ADDRESS <u>BOONSBORO MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 4/5

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06376

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (Specify place) 62 days		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Foun tain Head Heights				STREET ADDRESS (If rural, give location) Fountain Head Heights	
3. NAME OF DECEASED (First) William (Middle) Harry (Last) Reisner Sr.		4. DATE OF DEATH June 15 1951			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 7, 1865	9. AGE last birthday 86 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacture		10b. KIND OF BUSINESS OR INDUSTRY Organ Supplies		11. BIRTHPLACE (State or foreign country) Mercesburg Penn.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George Reisner		14. MOTHER'S MAIDEN NAME Ann C. Eckard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 220-09-9387		17. INFORMANT AND ADDRESS William H. Reianer Jr. Hag. Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardio-Renal Disease

INTERVAL BETWEEN ONSET AND DEATH

1949

Antecedent cause(s)

(b)

Arteriosclerosis

1943

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cardiac Failure

5 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15-1951 to June 15, 1951, that I last saw the deceased

alive on June 14, 1951, and that death occurred at 4:40a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Howard Yeager, M.D. Hagerstown, Md.

June 15, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 17, 1951

Phyllis H. Hoverson

Scott F. Minnich & Son Hag. Md.

290 399

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 19 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Frederick Road</u>		MARYLAND LENGTH OF STAY (in this place) <u>4 Days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Lappans</u> STREET ADDRESS (If rural, give location) <u>P.O. Farley Md.</u>	
3. NAME OF DECEASED (First) <u>Ida</u> (Middle) <u>Myrtle</u> (Last) <u>Rhodes</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>27</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Jan. 16, 1872</u>		9. AGE last birthday <u>79-5-11</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bum House</u>		11. BIRTHPLACE (State or foreign country) <u>Spilman Wash. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Caron Middlekraft</u>		14. MOTHER'S MAIDEN NAME <u>Laura Eakle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Fred L. Rhodes 815 Fred. Rd. Hagerstown Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary infarction

Antecedent cause(s)

(b)

Myocarditis Chronic

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from June 28, 1951, to June 27, 1951, that I last saw the deceased alive on June 26, 1951, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>June 30, 1951</u>		<u>Bakersville Cemetery</u>		<u>Bakersville Wash. Co. Md.</u>		<u>Md.</u>	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>June 29, 1951</u>		<u>Frank Powers</u>		<u>Wm. J. Best & Sons</u>		<u>Bethesda Md.</u>			

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06378

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>West Main Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Maxwell</u>	(Middle)	(Last) <u>Richards</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-31-70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker - Agricultural Bank</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Richards</u>		14. MOTHER'S MAIDEN NAME <u>Eve Ellen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mabel Brooks Richards (wife)</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
Immediate cause <u>151X Carcinoma of stomach</u>		(a)			
Antecedent cause(s) <u>46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		(b)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General arterio-sclerosis</u>		(c)			
19a. DATE OF OPERATION <u>Apr. 24, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of stomach</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr. 1, 1951, to June 28, 1951, that I last saw the deceased alive on June 27, 1951, and that death occurred at 7 a. m., from the causes and on the date stated above.

SIGNATURE R. S. Hauff (Degree or title) M.D. ADDRESS Hagerstown, Md. DATE SIGNED June 28, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 6-30-51 NAME OF CEMETERY OR CREMATORY Presbyterian Cem. LOCATION (City, town, or county) Hancock, Md. (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE June 29, 1951 - C. R. Bast 24. FUNERAL DIRECTOR Charles R. Bast, Hancock, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06379

Reg. Dist. No. 306

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Blue Ridge Summit</u>	
TOWN <u>Ritchie State Hosp.</u>		TOWN <u>Blue Ridge Summit</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Guy</u> (Middle) <u>Alvey</u> (Last) <u>Ridenour</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>10</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb. 22, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Washington Ridenour</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Amanda Ambrose</u>	
16. SOCIAL SECURITY NO. <u>209-12-6043</u>		17. INFORMANT AND ADDRESS <u>Hospital Record & Family</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Bronchogenic Carcinoma of the lung c metastasis.</u>			
Antecedent cause(s) (b) <u>162X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>47C</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Status post pneumonectomy</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 9, 1957, to June 10, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/13/1957</u>	<u>Bethel Church Cemetery</u>	<u>Washington Co. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 12-57</u>	<u>Wm. H. Ferguson</u>	<u>Haymabara</u>	<u>Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 47

762436

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06380

Reg. Dist. No. 352

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
TOWN <u>Washington County Hospital</u>		TOWN <u>Williamsport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>R.R. # 2</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Allen</u> (Middle) <u>Malme</u> (Last) <u>Shank</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 5, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>0</u> yrs. If under 1 year Months. <u>0</u> Days <u>0</u> Hours <u>28</u> Min.
13. FATHER'S NAME <u>Harold Lighter Shank</u>		11. BIRTHPLACE (State or foreign country) <u>United States</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
16. SOCIAL SECURITY NO. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Josephine McBrien</u>	
17. INFORMANT <u>mother</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>Immediate cause (a) <u>Prematurity - 28 weeks gestation</u></p> <p>Antecedent cause(s) (b) <u>776X 159 Intrauterine death of the other twin - Cause unknown.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Birth, 19....., to 6/6, 1951, that I last saw the deceased alive on 6/6, 1951, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

SIGNATURE Walter H. Shank M.D. ADDRESS Sharpsburg, Md. June 6, 1951 DATE SIGNED June 6, 1951

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE June 8, 1951 NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery, Williamsport, Md. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. June 8, 1951 REGISTRAR'S SIGNATURE Walter H. Shank 24. FUNERAL DIRECTOR Albert D. Lee, Williamsport, Md. ADDRESS

216051162 280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Bell

2411 N. Charles Street, Baltimore

06381

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>245 E. Irvin Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>245 E. Irvin Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lela Rose Simmers</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 14, 1876</u>
9. AGE last birthday <u>76</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Brewer</u>		14. MOTHER'S MAIDEN NAME <u>Betty Brewer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Wanda Simmers</u>			

18. MEDICAL CERTIFICATION 245 E. Irvin Ave.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

arteriosclerotic myocardial heart disease

acute coronary occlusion

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

arthritis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Sudden death</u>		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

SIGNATURE

S. Robert H. Wells, M.D.

DEPUTY MEDICAL EXAMINER
WASH. CO., MD.

DATE SIGNED

Hagerstown, Md., 6-14-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-14-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	LOCATION (City, town, or county) <u>Greencastle, Pa.</u>	(State)
DATE REC'D BY LOCAL REG. <u>June 14/1951</u>	REGISTRAR'S SIGNATURE <u>Charles B. Bower</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman, Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06382

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON COUNTY HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>23 CENTER ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>CARRIE</u> (First) <u>MAY</u> (Middle) <u>SMITH</u> (Last)		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>17</u> (Year) <u>51</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8/29/1889</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRONER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD CHARLES KLINE</u>		14. MOTHER'S MAIDEN NAME <u>LOLA CATHERINE KLINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>220-09-9072</u>	
17. INFORMANT AND ADDRESS <u>MR. CHARLES W. SMITH</u>		<u>23 CENTER ST. HAG. MD.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Adeno Carcinoma of uterus, metastasis to lung

INTERVAL BETWEEN ONSET AND DEATH

1 yr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to June 17, 1951, that I last saw the deceased

alive on June 16, 1951, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 18, 1951 Robert V. Campbell, M.D. 145 W. Washington St. Hagerstown, Md. 6/18/51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 443

Dr. Robert Campbell

9³⁰
am.

145 W. Washington St.

BUREAU V. S.

JUN 20 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06383

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hag erstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital		STREET ADDRESS 43 E. Lincoln Ave.	
3. NAME OF DECEASED (First) Sadie (Middle) Pauline (Last) Smith		4. DATE OF DEATH (Month) June (Day) 7 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 16, 1903
9. AGE last birthday 48 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Waynesboro Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Williams C. Loons		14. MOTHER'S MAIDEN NAME McPhern	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - - -	
17. INFORMANT AND ADDRESS Mr. Herman H. Smith Hag. Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Infarction	INTERVAL BETWEEN ONSET AND DEATH 6 days
584X Antecedent cause(s) (b) Intestinal Obstruction, Mechanical	2 weeks
126 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cholelithiasis		1 year
19a. DATE OF OPERATION 5-16-51	19b. MAJOR FINDINGS OF OPERATION Cholelithiasis, Adhesions with mechanical obstruction	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-7, 1950, to 6-7, 1951, that I last saw the deceased alive on 6-7, 1951, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

SIGNATURE <i>William M. Clety M.D.</i>	ADDRESS Hagerstown, Md.	DATE SIGNED 6-9-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 10, 1951	NAME OF CEMETERY OR CREMATORY Lutheran
LOCATION (City, town, or county) Boonesboro Md.	24. FUNERAL DIRECTOR Scott F. Minnich & Son	ADDRESS Hag. Md.
DATE REC'D BY LOCAL REG. June 9, 1951	REGISTRAR'S SIGNATURE <i>Phas P. Bowers</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 44

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06384

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. C. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1007 Hamilton Blvd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ethel Shufelt Spahr</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 15, 1884</u>
9. AGE last birthday <u>66</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles P Shufelt</u>		14. MOTHER'S MAIDEN NAME <u>Edith Heikelkaemper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Raymond A Spahr</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Embolism

INTERVAL BETWEEN ONSET AND DEATH

5 Mth.

Antecedent cause(s)

(b) Carcinoma of Cecum5 months

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) non-functioning Gall Bladder Chronic cholecystitis5 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>6-15-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Cecum</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	PLACE (Home, farm, factory, office bldg., etc.) INJURY _____	TOWN, COUNTY, STATE <u>Hagerstown, Washington, Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May 31, 1951, to June 15, 1951, that I last saw the deceasedalive on May 15, 1951, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-17-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	LOCATION (City, town, or county) <u>Hagerstown</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>June 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Frank Powers</u>	FUNERAL DIRECTOR <u>F. W. Kraiss</u>		ADDRESS _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A157

RECEIVED
JUN 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06385

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>1324 Fairchild Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>ANNE</u>	<u>MARGARET</u>	<u>STAKEM</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Nov. 10, 1880</u>
9. AGE last birthday	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>66</u>	<u>Government Clerk</u>	<u>Office</u>	<u>Coudersport, Penna.</u>
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
<u>USA</u>	<u>John Tomko</u>	<u>Mary Guydos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS	
<u>No</u>	<u>277-22-8831</u>	<u>Mrs Margaret Downey, Hagerstown Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cerebral Thrombosis

24 hr

Antecedent cause(s)

(b)

Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertension, Diabetes mellitus

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 1951, to June 15, 1951, that I last saw the deceased

alive on June 14, 1951, and that death occurred at 5:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 6, 1951

Robert H. Campbell

Andrew K. Coffman Hagerstown, Md.

390916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUN 20 1951

BUREAU V. S.

RECEIVED

JUN 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06386

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland WASH. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 N. Locust St.		STREET ADDRESS (If rural, give location) 310 N. Locust St.	
3. NAME OF DECEASED (Type or Print) Clinton A. Stouffer		4. DATE OF DEATH (Month) 6/11/51 (Day) 19 (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH 1/28/1862
9. AGE last birthday 89 yrs.		10. If under 1 year (Month) (Day) (Hour) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY Moller Organ Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Levi Stouffer		14. MOTHER'S MAIDEN NAME Margaret Lockler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. 220 10 3430	
17. INFORMANT AND ADDRESS Mrs. Grace Saylor Hagers.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Anterior subarachnoid hemorrhage 16 years

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/11/51, 19....., to 6/11/51, 19....., that I last saw the deceased

alive on 6/11/51, 19....., and that death occurred at 11:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6/14/51	NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	LOCATION (City, town, or county) Hagerstown, Md.	(State)
DATE REC'D BY LOCAL REG. June 14, 1951	REGISTRAR'S SIGNATURE Charles H. Bowers	24. FUNERAL DIRECTOR T. W. Kraiss	ADDRESS Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

910399

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JUN 18 1951

BUREAU 7.3

MARYLAND STATE DEPARTMENT OF HEALTH

06387

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

VS. A15
MARGIN RESERVED FOR BINDING
PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>218 Summer St</u>	
3. NAME OF DECEASED (Type or Print) <u>George William Swartz</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 1901</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) Conductor</u>		11. BIRTHPLACE (State or foreign country) <u>Clark Co. Va.</u>	
13. FATHER'S NAME <u>Augustus Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Clara E. Albright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mrs. Hannah R. Swartz</u>	
16. SOCIAL SECURITY No. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Hypertensive cardiovascular disease.</u>			<u>Years</u>
(b) <u>Antecedent cause(s)</u> <u>443X</u> <u>93d</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last			
(c) <u>Senile dementia</u>			<u>6 mos.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>41</u> , to <u>6-1-</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>51</u> , and that death occurred at <u>2:07 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Ka Bell</u>		ADDRESS <u>M.D. Hagers own, Maryland</u> DATE SIGNED <u>June 2, 1951.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 3, 1951</u> NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u> LOCATION (City, town, or county) <u>Hagerstown, Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>June 3, 1951</u>		24. FUNERAL DIRECTOR <u>Kraiss Funeral Home Hagerstown,</u> ADDRESS	

203506

RECEIVED
JUN 6 1951
BUREAU V. J.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06388

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fairplay</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES OSCAR SWARTZ</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 6 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/16/76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Clark Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-09-7498</u>	
17. INFORMANT AND ADDRESS <u>Robert C. Swartz Hagerstown Md</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary Occlusion

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 Days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/6/57, 19....., to 6/6/57, 19....., that I last saw the deceased alive on 6/6/57, 19....., and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/10/57</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 8, 1957</u>	<u>Chas. H. Powers</u>	<u>Rest Haven Funeral Chapel</u>	<u>Hagerstown Md.</u>	

82.0105 Hagerstown

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 416

RECEIVED
JUN 11 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

06389

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>517 Jefferson St.</u>	
3. NAME OF DECEASED (First) <u>DANIEL</u> (Middle) <u>E.</u> (Last) <u>THOMPSON</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 13 - 1951</u>
9. AGE last birthday <u>6</u> yrs. <u>16</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>		13. FATHER'S NAME <u>Daniel E. Thompson Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Loretta Mae Mc Kinsey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Daniel Edward Thompson Jr.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Intestinal Hemorrhage

Antecedent cause(s)

(b) Came not determined(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

3 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 1957, to June 28, 1957, that I last saw the deceasedalive on June 28, 1957, and that death occurred at 3:11 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 29, 1957Black HagerstownWest Hagerstown Funeral ChapelHagerstown Md.

206131151406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> LENGTH OF STAY (If this place) <u>3 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u> TOWN <u>Funkstown</u> STREET ADDRESS (If rural, give location) <u>Beaver Creek Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ALICE</u> <u>REED</u> <u>TROXELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>19</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 27, 1866</u>
9. AGE last birthday <u>84</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Funkstown, Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Joseph Reed</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dusong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Hugh Troxell, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

6-3-51

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 3, 1951, to June 19, 1951, that I last saw the deceased alive on June 19, 1951, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>	LOCATION (City, town, or county) (State) <u>Funkstown Maryland</u>
DATE REC'D BY LOCAL REG. <u>June 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Edna H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3010

06391

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u> TOWN <u>Cascade</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>RFD # 4</u>	
3. NAME OF DECEASED (Type or Print) <u>Fannie</u> (First) <u>Kate</u> (Middle) <u>Turner</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>2</u> (Day) <u>1951</u> (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 3, 1869</u>	9. AGE last birthday <u>81</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Isaiah Shove</u>		14. MOTHER'S MAIDEN NAME <u>Rhodenizer (Harriett Ellen)</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT AND ADDRESS <u>Hospital Record</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Adenocarcinoma of cervix of uterus6 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertensionmany yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 9, 1949, to June 2, 1951, that I last saw the deceasedalive on June 2, 1951, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel RaiM.D. Ritchie Hospital, Cascade, Md. 6/2/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 7, 1951Rev. W. FergusonAndrew K. Coffman Hagerstown

Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

06392

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 Winter St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>111 Winter St.</u>	
3. NAME OF DECEASED (First) <u>DAVID</u> (Middle) <u>MARION</u> (Last) <u>VANCE</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/11/1887</u>
9. AGE last birthday <u>63</u> yrs.		10. AGE last birthday If under 1 year Months <u> </u> Days <u> </u> If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David E. Vance</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Shadrach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Viola Vance, Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Coronary Vascular Disease

93d Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH 6 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7/1/50, 19....., to 6/6/51, 19....., that I last saw the deceased alive on 6/4/51, 19....., and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>June 8, 1951</u>	REGISTRAR'S SIGNATURE <u>Shadrach H. Lowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1961
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06393

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Penna.</u> COUNTY <u>Dauphin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>34 High Street</u>		STREET ADDRESS (If rural, give location) <u>625 Dumble St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edith</u> (Middle) <u>M.</u> (Last) <u>Wallace</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 25, 1879</u> 9. AGE last birthday <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Charles Fleet</u>		14. MOTHER'S MAIDEN NAME <u>Louise Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Ruth Keeley - 34 High Street</u>
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>(a) Arterio-sclerotic myocardial heart disease</u>			
Antecedent cause(s) <u>(b) Acute coronary occlusion</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c)</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>S. Robert Wells, M.D.</u>		DEPUTY MEDICAL EXAM. ADDRESS <u>115 N. Potomac Hagerstown, Md.</u> DATE SIGNED <u>6/20/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>6/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG <u>June 20, 1951</u>	REGISTRAR'S SIGNATURE <u>G. H. H. H. H. H.</u>	24. FUNERAL DIRECTOR ADDRESS <u>J. W. Kraiss</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06394

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beverly Manor</u>		STREET ADDRESS (If rural, give location) <u>Beverly Manor, No St. Address</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Dollie</u>	(Middle) <u>Ann</u>	(Last) <u>Walters</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>51</u>
8. DATE OF BIRTH <u>11-20-1881</u>		9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Luray, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Huffman</u>		14. MOTHER'S MAIDEN NAME <u>Amanda C. Foltz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Norman Walters, Hagerstown, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

600.0 Immediate cause

(a) Chronic Pyelonephritis with Uremia

INTERVAL BETWEEN ONSET AND DEATH

4 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Anemia, Microcytic, Svere

3 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-13, 1947, to 6-5, 1951, that I last saw the deceased

alive on 6-5, 1951, and that death occurred at 5:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dalton M. Welty M.D.

7 Hagerstown, Md. 6-6-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

Rose Hill Mausoleum

Hagerstown, Maryland

24. FUNERAL DIRECTOR

ADDRESS

June 6, 1951

Frank H. Bowers

E. M. Suter & Sons, Hagerstown, Maryland

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A45

For W. J. J.

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06395

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>77 Wise Street</u>		STREET ADDRESS (If rural, give location) <u>77 Wise Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ethel</u> (Middle) <u>Henrietta</u> (Last) <u>Wiley</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-25-1883</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year: Months <u>2</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Taneytown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Laura Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Blanche Rockwell, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of cervix - primary

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of cervix - primary(c) Chronic Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 years5-8-19455-29-48

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(6-26-51 ams)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 23, 1928, to June 13, 1951, that I last saw the deceasedalive on June 12, 1951, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-15-1951</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 15, 1951</u>		<u>Frank H. Hower</u>		<u>C. M. Suter & Sons, Hagerstown, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1951
BUREAU V. S.